



Handbook for Providers of Audiology Services

Chapter E-200 Policy and Procedures for Audiology Services

Illinois Department of Public Aid

CHAPTER E-200

AUDIOLOGY SERVICES

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of providers who provide audiology items or services for participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's website at

<http://www.state.il.us/dpa/handbooks.htm>

This handbook provides information regarding specific policies and procedures relating to audiology services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

CHAPTER E-200

AUDIOLOGY SERVICES

E-200 BASIC PROVISIONS

For consideration to be given by the Department for payment of audiological or hearing aid services, such services must be provided by an audiologist or a hearing aid retailer enrolled for participation in the Department's Medical Programs. Services provided must be in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures (Chapter 100), and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

E-201 PROVIDER PARTICIPATION

E-201.1 PARTICIPATION REQUIREMENTS

An audiologist who has a master's degree, a doctor of philosophy degree in audiology, or a doctor of audiology degree and who is licensed by the Department of Professional Regulation or the state of practice is eligible to be considered for enrollment to participate in the Department's Medical Programs.

A hearing aid dispenser who is not an audiologist but is registered by the Illinois Department of Public Health to do hearing aid testing and to dispense hearing aids is eligible to be considered for enrollment to participate in the Department's Medical Programs. If such enrollment is granted, the non-audiologist hearing aid dispenser is enrolled as a medical equipment provider who may provide the two tests and evaluation services related to hearing aids, the hearing aids, and hearing aid-related services such as accessories, supplies and repairs.

The Department's list of allowable procedures for services or items for audiologists or hearing aid dispensers is on the Department's website at:

<http://www.state.il.us/dpa/html/medicaidreimbursement.htm>

Refer to E-202.5 for more information regarding the Department's fee schedules on the website.

Procedure: The provider must complete and submit:

- Form DPA 2243 Provider Enrollment/Application
- Form DPA 1413 Agreement for Participation
- W9 Request for Taxpayer Identification Number

These forms may be obtained by calling the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217) 782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the address listed on the previous page. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

E-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data in the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix E-5 and E-5a.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic E-201.4.

E-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten days after such notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

E-201.4 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in Department files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time a provider makes a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change.

PROCEDURE: The provider must line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

Whenever there is any change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to any payees listed if the payee address is different from the provider address.

E-202 PROVIDER REIMBURSEMENT

E-202.1 CHARGES

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department **after** the service or item has been provided.

A provider may only charge for services he or she personally provides, or which were provided under his or her direct supervision in the provider's office by the provider's staff. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

Hearing Aids - Charges for hearing aids is the **actual acquisition cost** of the hearing aid. In addition to the hearing aid(s) a separate charge may also be submitted for the Department's established dispensing fee. Refer to Topic E-203.3 for an explanation of services covered in the dispensing fee.

NOTE: No separate additional charge is to be made for freight, postage, delivery, instruction, fitting, adjustments, or measurement, since these services are considered to be all-inclusive in a provider's charge for the item or service requested. These additional charges **cannot** be billed to the patient. Refer to Chapter 100, Topic 114.

The actual acquisition cost is the actual payment by the supplier for the hearing aid, taking into account any discounts, rebates or bonuses. The full amount of the discount must be subtracted when calculating the acquisition cost. The amount of any rebates or bonuses must be prorated to all purchases on which the rebate or bonus was earned. The prorated share must be subtracted when calculating the acquisition cost of the hearing aid.

The date of service to be submitted for a hearing aid is the date the hearing aid is dispensed, not the fabrication date. The participant must be eligible on the dispensing date for providers to receive reimbursement from the Department.

E-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in the Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies, or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims submittals are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

E-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix E-4.

Form DPA 1443, Provider Invoice, must be used to submit charges for audiological services provided to a Department's Medical Programs participant. Refer to Appendices E-1 and E-1a for a copy of the Provider Invoice and instructions for completion and submittal.

Form DPA 2210, Medical Equipment/Supplies Invoice, must be used to submit charges to the Department for a hearing aid, hearing aid accessories, supplies, hearing aid repairs and the dispensing fee. Refer to Appendices E-2 and E-2a for a copy of the invoice and instructions for completion and submittal.

All services for which charges are made must be coded on the appropriate claim form with specific procedures that may be found on the Department's website. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

The Department uses a claim imaging system to scan paper claims. The imaging system allows more efficient processing of paper claims and also allows for essential attachments to be scanned. Refer to Appendix E-1 and E-2 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability and imaging evaluation. Please send sample claims with a request for evaluation to the following address:

Illinois Department of Public Aid 201 South Grand Avenue East Second Floor - Data Preparation Unit Springfield, Illinois 62763-0001 Attention: Vendor/Scanner Liaison

E-202.31 Claims Submittal

All routine paper claims submitted on the form DPA 1443, Provider Invoice, are to be submitted in Form DPA 1444, Provider Invoice Envelope. All routine paper claims submitted on the form DPA 2210, Medical Equipment/Supplies Invoice, are to be submitted in the Form DPA 2247, Provider Invoice Envelope. These envelopes are pre-addressed mailing envelopes provided by the Department for this purpose. Use of these pre-addressed envelopes should insure that claim forms will arrive in their original condition and that they will be properly routed for processing.

For a non-routine claim, use Form DPA 2248, Special Handling Envelope. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other document is attached.

For electronic claims submittal, refer to Topic E-202.2. Non-routine claims may not be electronically submitted.

E-202.4 PAYMENT

Payment made by the Department for professional services and for hearing aid accessories, supplies and hearing aid repairs will be at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

Audiological services provided in a hospital, either inpatient or outpatient, are included in the Department's payment to the hospital. The individual audiologist who is salaried by the hospital will not be paid for services provided in the hospital.

Hearing Aids and Accessories

Payment for the provision of a hearing aid is the actual acquisition cost plus a dispensing fee established by the Department. Refer to Topic E-203.3 for an explanation of services covered in the dispensing fee.

E-202.5 FEE SCHEDULES

The Department's maximum reimbursement rates for the allowable procedures are listed on the Department's website. The listing can be found at

<http://www.state.il.us/dpa/html/medicaidreimbursement.htm>

Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The maximum rates, quantity limitation, whether the item is covered for residents of Long Term Care facilities and prior approval requirements for each item are also available electronically. The Department maintains a downloadable rate file suitable for use in updating a provider's computerized billing system. This file is located in the same area on the Department's website as the alphabetical and numerical listings described above. A copy of this file can also be obtained by sending a blank 3.5 inch IBM PC compatible diskette, a written request and a self-addressed, prepaid diskette mailer to the address listed above.

The website listings and the downloadable rate file are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

For DME providers and audiologists who provide hearing aids and hearing aid supplies there is an alphabetical listing by service or item and a numerical listing by HCPCS code. For an **audiologist** professional services there is an alphabetical listing by service or item.

E-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

Audiologists who bill the Department for payment must have in the patient file a referral from a physician, i.e., an otologist, otolaryngologist or the primary care physician, as applicable.

Any question a provider may have about coverage of a particular service must be directed to the Department prior to provision of the service. Providers may call the Bureau of Comprehensive Health Services at 217-782-5565.

If services are to be provided to a participant enrolled in a managed care organization (MCO), prior authorization and payment must be obtained from the MCO.

E-203.1 AUDIOLOGISTS

Audiologists are covered to provide basic and advanced hearing tests. They are also covered to provide hearing aid related testing and evaluation, hearing aid counseling, hearing aid fitting, and sale of the hearing aid itself. Coverage also includes provision of hearing aid accessories, replacement of parts, and repairs.

There are three procedure codes (92506, 92507 and 92510) for audiologists only which pertain to follow-up services after a cochlear implant. The three codes are not to be used under any other circumstance.

An audiologist who sells and dispenses hearing aids in addition to providing professional audiology services is expected by the Department to adhere to statutes guaranteeing the patient's freedom of choice of providers. The audiologist must instruct the patient that they may obtain a hearing aid from any seller or dispenser who can supply the appropriate aid.

E-203.2 NON-AUDIOLOGIST BUSINESSES

Non-audiologist businesses provide durable medical equipment and supplies (DME providers). The DME provider may provide hearing aids and hearing aid-related services and items but not professional audiology services for which an audiologist's academic credentials and licensing are required.

Non-audiologist providers of hearing aids (DME providers) are covered to provide hearing aid-related testing and evaluation, hearing aid counseling, hearing aid fitting, and sale of the hearing aid itself. Coverage also includes provision of hearing aid accessories, replacement of parts, and repairs.

E-203.3 HEARING AIDS

A dispensing fee may be billed at the time the hearing aid is delivered to the patient. The dispensing fee includes, but is not limited to payment for fitting, follow-up visits, shipping fee and retail mark-up for the hearing aid.

Payment by the Department is allowable only up to an average of sixteen batteries per hearing aid in a 60 day period.

EXCEPTION: Payment will not be made for hearing aid batteries for residents in a Long Term Care Facility (LTC). It is the responsibility of the LTC Facility. The cost of the hearing aid batteries are included in the payment made by the Department to the LTC Facility.

Provision of a hearing aid, whether by an audiologist or a DME provider, must include a minimum of a one-year warranty at no expense to the Department. Repair costs covered by the warranty are not to be submitted to the Department for payment.

E-203.31 Monaural Hearing Aids

In order to be eligible for reimbursement from the Department for monaural hearing aids, the following criteria **must** be met:

When testing is performed in an acoustically treated sound suite:

The hearing loss must be 20 decibels (dB) or greater at any two of the following frequencies: 500, 1000, 2000, 4000, 8000 Hertz (Hz),
or

The hearing loss must be 25 dB or greater at any one of 500, 1000, 2000 Hz.

When testing is performed in other than an acoustically treated sound suite:

The hearing loss must be 30 dB or greater at any two of the following frequencies:
500, 1000, 2000, 4000, 8000 Hz,

or

The hearing loss must be 35 dB or greater at any one of 500, 1000, 2000 Hz.

E-203.4 EARLY INTERVENTION SERVICES

Early Intervention (EI) services are covered only for children up to the age of three years, who are eligible for Part C services under the Individuals with Disabilities Education Act and when those services are included in the child's Individualized Family Service Plan. Procedure codes for EI services must be billed to the EI Central Billing Office (CBO) for payment. In order to receive payment from the CBO, a provider must apply for and obtain an Early Intervention Credential, enroll as a provider with the CBO, and have prior authorization to provide services.

- For credential and enrollment information, contact Provider Connections at 1-800-701-0995.
- For questions about the service authorization and billing processes, contact the Early Intervention CBO Cornerstone Call Center at 1-800-634-8540.

E-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered in the Department's Medical Programs. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

In addition, the following services are excluded from coverage in the Department's Medical Programs and payment cannot be made for the provision of these services:

- routine periodic exams in the absence of an identified problem
- examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from non-medical funds. Audiologists are to follow specific billing instructions given when such a request is made.)
- services provided in federal or state institutions
- expenses associated with postage and handling for any items
- travel expenses to provide testing

NOTE: No separate additional charge is to be made for freight, postage, delivery, instruction, fitting, adjustments, or measurement, since these services are considered to be all-inclusive in a provider's charge for the item or service requested. These additional charges **cannot** be billed to the patient. Refer to Chapter 100, Topic 114.

E-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

In the absence of proper and complete medical records , no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

Providers must maintain an office record for each patient. In group practices, partnerships, and other shared practices, one record must be kept with chronological entries by the individual provider rendering services.

The record maintained by the audiologist must include the essential details of the patient's condition and of each service or item provided. Any services provided a patient by the audiologist outside the audiologist's office are to be documented in the medical record maintained in the audiologist's office. All entries must include the date and must be legible. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition, treatment, and services ordered and provided during the period of institutionalization may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, dates and times services were provided, must be maintained by the audiologist as an office record to show continuity of care.

In addition to record requirements discussed in the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures, an audiologist's records are to include the following information:

- A copy of the referral from the physician (otologist, otolaryngologist, or primary care physician)
- A copy of the manufacturer's invoice with the patient's name and hearing aid serial number
- Hearing aid evaluation results

- Diagnosis
- Audiogram
- Medical history relevant to audiology services
- Dates services or items were provided
- A copy of the manufacturer's invoice for an ear mold, if applicable

E-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services, or dispensing of certain materials, approval must be obtained from the Department.

If charges are submitted for services which require prior approval and approval was not obtained, payment will not be made for services as billed. Refer to Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provider services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

E-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the item or service. When it is necessary to provide an item or service outside of routine business hours, refer to Chapter 100, Topic 111.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

The following items or services may be provided only with prior approval by the Department:

- Binaural hearing aids for adults (individuals over the age of 18)
- Monaural hearing aid – creating a binaural situation for adults (individuals over the age of 18)
- Hearing aid and dispensing fee – replacement is within three years of the initial or previous purchase
- Exceed quantity limits in allotted time frame(s)
- Repair costs over \$250.00

A prior approval request to provide hearing aids must be accompanied by the following:

- A copy of a physician's clearance or physician's order to allow the hearing aids to be fitted. The physician's signature must be dated within the past twelve months. The original clearance or order must be retained in the patient's record.
- The audiogram with the written recommendation.
- Documentation that reflects the actual acquisition cost of the hearing aid(s).
- If requesting binaural hearing aids, a Form M-206.26a, Binaural Hearing Aid Questionnaire, completed by the ordering physician. Appendix E-3b contains a facsimile of Form M-206.26a. This form provides a convenient format for supplying the required information. However, it is not required that the form itself be used, if all the necessary medical information is supplied in another format.
- If requesting replacement of a monaural hearing aid within three years, a letter of explanation as to why a new hearing aid is needed, a copy of the audiogram and a copy of the cost invoice.

EXCEPTION: If such replacement aid is requested within one year of the previous aid, the copy of the audiogram is not required.

A prior approval request to provide repairs costing more than \$250.00 must be accompanied by an itemized breakdown of the specific repairs needed and the charge for each.

By Mail:

Prior approval to provide the above described items or services must be requested by the provider using Form DPA 2240, Equipment Prior Approval Request. Refer to Appendix E-3 for instructions for completing Form DPA 2240, Equipment Prior Approval Request. Requests may be mailed to the Department in the Form DPA 2294, Prior Approval Request Envelope.

By Fax:

Prior approval may be requested by fax. Complete Form DPA 2240, following the procedures described above for mailed requests. The completed form, the physician order and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will

be legible upon receipt. Colored documents, including the pink Form DPA 2240, often do not fax clearly. The Department recommends that such documents be photocopied and that the copy be faxed.

The fax number for prior approval requests is 217-524-0099. This fax is available 24 hours a day. Requests faxed during non-business hours will be considered to have been received on the next normal business day.

By Telephone:

When prior approval is requested by telephone, the request will be data entered by staff at one of the following telephone numbers:

217-785-6239
217-524-0005
217-524-7354
217-524-7357

These numbers are available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the DPA 2240.

The provider is responsible for having a valid physician order and statement of medical necessity which bears the ordering physician's signature at the time of the request. The Department reserves the right to request proof of documentation before approval is granted.

After a decision is made regarding the prior approval request, a notification, Form DPA 3076A or 3076D, is returned to the provider with an approval or denial indicated.

E-211.2 POST APPROVAL

To be eligible for post approval consideration, the requirements for prior approval must be met and post approval requests must be received by the Department no later than 90 days from the date the item or service was provided. Exceptions to this requirement are permitted only in the following circumstances:

- The patient's application for Medical Assistance or KidCare has been filed but approval has not been received as of the date of service. In such a case, the post approval request must be received no later than 90 days following the

date of approval of the Medical Assistance application.

- The patient did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received no later than six (6) months following the date of service **and** will be considered for payment only if there is attached to the request a copy of the provider's dated private-pay bill or collection correspondence, which was addressed and mailed to the patient each month following the date of service.
- A request for payment was submitted to a third party resource within six (6) months following the date of service. In such a case, a post approval request must be received by the Department no later than 90 days from the date of final adjudication by the third party. Third party documentation must be attached.

If charges are submitted for services which require prior approval and approval was not obtained, payment will not be made for services as billed.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

The approval to provide the item or service does not include approval of the provider's charge. If a service without a specified maximum rate, i. e., repairs over \$250.00, is approved, the Department will specify the approved amount with approval of the service. The provider and the patient will be advised by the Department of approval or denial of the request.

When billing the Department for an item or service which has been approved for a patient, the provider must submit the claim as a routine claim.